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NAME_____ DATE_____

℞ ADDRESS_____ CALIF.

① Phenothiazines → Thorazine sustain rel. or tabs.

② Sinequan 100 mg. @ hs to be increased

③ Muscle relaxant or pain med only for severe HA.

LABEL AS SUCH

_____ M. D.

REP.____TIMES
NE REP. ☐